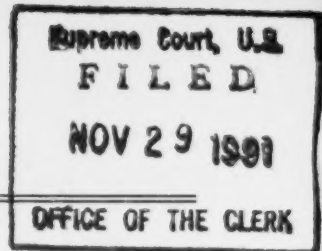


(3)

No. 91-732



In The
Supreme Court of the United States
October Term, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,

Petitioners,

v.

TEMPLE UNIVERSITY - OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,

Respondents.

Petition For A Writ Of Certiorari To The
United States Court Of Appeals
For The Third Circuit

BRIEF OF RESPONDENTS, ALBERT EINSTEIN
MEDICAL CENTER, ET AL., IN OPPOSITION TO
PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

- I. Whether this Court should overrule its own recent decision in *Wilder v. Virginia Hospital Ass'n*, ___ U.S. ___, 110 S. Ct. 2510 (1990), holding that the Boren Amendment is enforceable in an action brought by health care providers under Section 1983.
- II. Whether the narrow ruling below on Medicaid disproportionate share adjustments constituted an abuse of discretion under the circumstances presented?¹

¹ A list of the respondents on whose behalf this brief in opposition is filed, along with the disclosures required by Sup. Ct. R. 29.1, is set out in the Appendix to this brief ("Resp. App.").

TABLE OF CONTENTS

	Page
Counterstatement of Questions Presented	i
Table of Citations	iv
Opinions Below and Statement of Jurisdiction.....	1
Counterstatement of the Case.....	1
Reasons for Denying the Writ	4
I. THE ARGUMENTS URGED BY PETITIONERS FOR REVIEW OF <i>WILDER</i> ARE BASED ON MIS- CONCEPTIONS AND IN FACT SUPPORT DENIAL OF REVIEW	4
A. It Is A Misconception For Petitioners To Sug- gest There Exists Meaningful Federal Agency Oversight As A Basis to Reconsider <i>Wilder</i>	5
B. Petitioners Are Disingenuous In Suggesting The Availability Of An Alternative State Remedy As A Basis To Reconsider <i>Wilder</i>	8
C. Petitioners Have Only To Fear Their Own Illegal Agency Action; They Can Hardly Be Heard to Complain That Provider Litigation Is A Basis To Reconsider <i>Wilder</i>	10
II. PETITIONERS FAIL TO PRESENT A COMPEL- LING CLAIM FOR REVIEW OF THE DISPROPOR- TIONATE SHARE ADJUSTMENT RULING	12
A. The Decision That Petitioners Would Have This Court Review Is Not Of General Appli- cability But Is So Narrow As To Not Warrant Review.....	12

TABLE OF CONTENTS - Continued

	Page
B. The Case Has Been Settled, And Further Review Would Essentially Be An Academic Exercise.	17
C. Review Should Be Denied Since The Statutory Issue Was In Any Case Correctly Decided Below.....	18
Conclusion	22

TABLE OF CITATIONS

	Page
CASES	
<i>Harrison v. PPG Industries, Inc.</i> , 446 U.S. 578 (1980)	19
<i>Miami Heart Institute v. Sullivan</i> , 868 F. 2d 410 (11th Cir. 1989).....	19
<i>National Muffler Dealers Ass'n, Inc. v. United States</i> , 440 U.S. 472 (1979)	19
<i>Pennhurst State School & Hospital v. Halderman</i> , 451 U.S. 1 (1981)	18
<i>United States v. Vogel Fertilizer Co.</i> , 455 U.S. 16 (1982)	19
<i>West Virginia University Hospitals, Inc. v. Casey</i> , 885 F.2d 11 (3d Cir. 1989), <i>cert. denied</i> , ___ U.S. ___, 110 S. Ct. 3213 (1990), <i>cert. granted and aff'd on</i> <i>other grounds</i> , ___ U.S. ___, 111 S. Ct. 1138 (1991)	9
<i>Wilder v. Virginia Hospital Ass'n</i> , ___ U.S. ___, 110 S. Ct. 2510 (1990).....	<i>passim</i>
STATUTES AND REGULATIONS	
55 Fed. Reg. 56132.....	14
55 Fed. Reg. 10078.....	20
42 U.S.C. §1396, et seq.	<i>passim</i>
55 Pa. Code §1101.84	8
1 Pa. Code §§35.1-35.251.....	8
Omnibus Budget Reconciliation Act of 1990, P.L. No. 101-508	14
OTHER AUTHORITIES	
SANDS, 2A SUTHERLAND STATUTORY CONSTRUCTION (4th ed. 1984)	19
H.R. Rep. No. 100-391	21

BRIEF OF RESPONDENTS, ALBERT EINSTEIN MEDICAL CENTER, ET AL., IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

This brief in opposition to the Petition for Writ of Certiorari (the "Petition") is filed on behalf of respondents, Albert Einstein Medical Center, et al., appellees in the case *Albert Einstein Medical Center, et al., v. White, et al.*, No. 90-1203 (3d Cir.) (the "*Einstein Appeal*").

**OPINIONS BELOW AND
STATEMENT OF JURISDICTION**

The opinions below are set out at page 1 of the Brief for Petitioners ("Pet. Br."), and are found in Petitioners' Appendix ("Pet. App."). The statement of this Court's jurisdiction is found in Pet. Br. at page 2.

COUNTERSTATEMENT OF THE CASE

This action began in 1988 when the Pennsylvania Department of Public Welfare ("DPW") issued rate notices to acute care hospitals participating in the Medicaid Program, setting forth their group "base" rates for reimbursement for the medical care they give to the medically indigent, and (for qualifying hospitals) the disproportionate share "add-on" rate designed to compensate a minority of hospitals (which so qualify) for the extra costs incurred in caring for high concentrations of indigent

patients.² Of the fifteen original *Einstein* plaintiff hospitals, three have since filed for bankruptcy. See Resp. App. at 2a. Plaintiffs brought suit to challenge the unlawful base rates announced by Pennsylvania for its Medicaid reimbursement to acute care hospitals, as well as (in the case of the qualifying hospitals) the unlawful disproportionate share add-ons.³

The case instituted by co-respondent Temple University Hospital ("Temple") was calendared for trial, and the plaintiffs in *Einstein* contemporaneously moved for summary judgment. The District Court subsequently determined, following the trial in *Temple*, that the group base rates violated both the procedural and substantive requirements of the Medicaid Act, as embodied in the "Boren Amendment."⁴ Pet. App. 91a-92a. This ruling was based, *inter alia*, on the Court's determinations that Pennsylvania had effectively reduced the group rates in a

² The Medicaid Program is a joint federal-state program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§1396, 1396(a)-1396(u). Congress has determined as a matter of legislative fact that significant additional costs are incurred by hospitals that treat a disproportionate number of indigent patients. Disproportionate share add-on adjustments designed to compensate such hospitals are governed by 42 U.S.C. §1396r-4(b).

³ Under its Medicaid System, most general acute care hospitals were included in one of seven groups, each of which was assigned a prospective group-wide payment rate.

⁴ The Boren Amendment sets forth requirements states must meet when setting the reimbursement rates to which hospitals, nursing homes and intermediate care facilities are entitled. 42 U.S.C. §1396a(a)(13)(A). See also, *Wilder v. Virginia Hospital Ass'n*, ___ U.S. ___, 110 S. Ct. 2510, 2513-2514, n.2 (1990).

manner that was not authorized under the terms of its then binding State Plan, and that DPW arbitrarily effected an across-the-board reduction – or “lop off” – solely to accomplish budgetary objectives. The Court further found that DPW never defined, let alone assessed, the costs that must be incurred by an efficiently and economically operated hospital – despite “assuring” HCFA that it had factually found that its rates were indeed adequate in this respect. The District Court also declared that the special disproportionate share add-on payment DPW had made to Temple was legally inadequate.

Having declared Pennsylvania’s Medicaid rates unlawful, the District Court ordered DPW to construct a revised State Plan and to pay Temple an interim disproportionate share add-on equal to less than half of its Medicare disproportionate share add-on pending the State’s adoption of a revised State Plan. After disposing of *Temple*, the District Court granted permanent injunctive relief as to the *Einstein* hospitals, requiring that their base rates be upwardly adjusted by approximately 14% to eliminate the unlawful “lop off” – which the District Court considered DPW’s most clear cut and egregious error – pending adoption of the revised State Plan.

The United States Court of Appeals for the Third Circuit, having consolidated the cases on appeal, affirmed those rulings. Pet. App. 27a. Thereafter, the parties entered into a comprehensive stipulation of settlement which currently is in effect. Pet. App. 17a, n.5.

Petitioners do not urge that the lower courts erred in holding that DPW violated the Medicaid Act in promulgating the base rates (which account for the vast

majority of the Medicaid payments). Rather, Petitioners seek entirely to insulate their rate setting process from judicial review by challenging the very right of Respondents to institute actions in federal court. Petitioners seek a merits review only of the disproportionate share add-on adjustment.

This opposition to certiorari is submitted by the remaining twelve hospitals in the *Einstein* Appeal. These hospitals are predominantly inner-city institutions treating high concentrations of the medically indigent. While the *Einstein* Respondents join in the presentations by their respective co-respondents, they file this separate opposition to the writ to augment those presentations.

REASONS FOR DENYING THE WRIT

I. THE ARGUMENTS URGED BY PETITIONERS FOR REVIEW OF *WILDER* ARE BASED ON MISCONCEPTIONS AND IN FACT SUPPORT DENIAL OF REVIEW

Petitioners do not challenge the merits of the rulings below as to the base payment rates. Instead, they request the Court to overrule *Wilder v. Virginia Hospital Ass'n*, ___ U.S. ___, 110 S. Ct. 2510 (1990), a case decided scarcely eighteen months ago. In support of their request, three spurious propositions are advanced by Petitioners. When properly brought into focus, each of the propositions in fact supports denial of the writ.

A. It Is A Misconception For Petitioners To Suggest There Exists Meaningful Federal Agency Oversight As A Basis to Reconsider *Wilder*.

Petitioners rely heavily on purported oversight by the federal bureaucracy over state Medicaid reimbursement programs (Pet. Br. at 24, 28) as a basis for their Petition. However, the federal bureaucracy does little in the way of oversight. The flagrant agency abuse by Petitioners in this case – their failure to adhere to the most basic federal statutory and regulatory requirements – both proves that the argument urged by Petitioners is misconceived, and, by virtue of the highly case-specific conduct in question, makes this case inappropriate for review.

It is true that the states must submit a "State Plan" to the Health Care Financing Agency ("HCFA"), which must be reviewed and approved by HCFA as a condition to receiving federal matching funds under Title XIX. Under Title XIX, the State Plan represents the legally binding program for the state's reimbursement of providers (i.e., hospitals) for the provision of services to Medicaid patients. The statute also requires that the state make "findings" and provide "assurances" to HCFA that its State Plan complies with federal law, including that it affords "reasonable and adequate" reimbursement. HCFA, however, does not directly scrutinize the adequacy of State Plans; rather, as the Court below stated, HCFA "relies on the state's 'assurances' and does not independently evaluate the adequacy of the rates." Pet. App. 20a. By making sham "findings" and mechanical "assurances," the states can circumvent meaningful oversight.

This case presents the clearest such example. Petitioners egregiously broke the law in two ways. First, Petitioners employed a "lop off" factor (roughly 14%) to cut the reimbursement rates that would have been derived by adhering to the methodology actually set forth in Pennsylvania's own State Plan. Pet. App. 21a-22a. After calculating the rates in the fashion required by the State Plan, Petitioners then unlawfully reduced the rates called for by the State Plan by a so-called "budget neutrality factor" – the "lop off" – which had the effect of reducing the projected aggregate amount that would be paid to hospitals so that the amount would not exceed the previously-enacted budget appropriation. This "lop off" was found below to be in clear contravention of the State Plan and, thus, federal law. The Court below squarely noted that the "lop off" was solely "designed to restrict total MAP payments to the respective hospitals to the amount of the total inpatient budget appropriation for 1988-1989," Pet. App. 21a-22a, and affirmed its illegality.⁵

Having done this, Petitioners then proceeded to provide assurances to the federal government that Pennsylvania's rates were reasonable and adequate, and that they had made findings to support their assurances. Petitioners' assurances and findings, however, were fictitious. The District Court found that Petitioners made no findings based upon empirical studies as to critical areas relating to the matters for which assurances were

⁵ The interim relief granted below took into account the maximum adjustment that would have been allowed had DPW actually adhered to its State Plan.

required. The Court of Appeals squarely addressed Petitioners' failure to make findings:

Thus, DPW had conducted no analysis and had made no findings as to the reasonableness or adequacy of its rates to cover the costs of an efficiently and economically operated hospital or to account for the impact on a hospital of its across-the-board budget neutrality adjustment and varying percentage add-ons for disproportionate-share hospitals. Nor did DPW identify any findings which it made pertaining to "reasonable access to inpatient hospital care." Indeed, DPW admitted as much during pretrial discovery.

Pet. App. 25a-26a. The Court of Appeals then unanimously concluded that any "assurances" made by Petitioners were illusory:

Without knowledge of hospital costs, DPW could not have known what an efficient and economical hospital operation would entail, let alone what payment rates would be reasonable and adequate to meet that hospital's costs and assure reasonable access to hospital care. In the absence of essential data and information, DPW was in no position to make findings, and clearly did not do so. Any assurances DPW made to the Secretary were, therefore, without foundation.

Pet. App. 27a.

The facts which underlie Petitioners' unlawful agency actions present unique and case-specific circumstances which, taken in their totality, create a record so devoid of merit for reversal that Petitioners have not even sought to challenge the determination that their base

rates violated the Medicaid statute. Given the unpromising record, and the overwhelming merits for affirmance, the present appeal is the last case in which *Wilder* should be reconsidered.⁶

B. Petitioners Are Disingenuous In Suggesting The Availability Of An Alternative State Remedy As A Basis To Reconsider *Wilder*.

Petitioners allude at some length to Pennsylvania's "extensive state administrative payment rate review process." Pet. Br. at 22. Petitioners fail to candidly address the severe shortcomings of that process in Pennsylvania; those shortcomings reinforce the inappropriateness of this case as an opportunity to reconsider *Wilder*.

Pennsylvania's state-level adjudicative processes are "nasty, brutish and short." It is true that hospitals in Pennsylvania may file administrative claims before the Office of Hearings and Appeals ("OHA"), Petitioners' captive tribunal, and then seek judicial review of the final administrative decision through appeal to the Commonwealth Court. See 55 Pa. Code §1101.84, 1 Pa. Code

⁶ This case is also particularly inappropriate for review since the parties have arrived at a settlement which is currently in effect. This court should not undertake review of cases in which the Court's ruling would effectively be meaningless. A settlement agreement has now been in effect for six months which provides that the base rates paid by Pennsylvania - higher than those which were directed by the District Court - will not be altered even if this Court were to grant certiorari and reverse, so long as the other completely ancillary conditions of the settlement remain in effect (as they have to this date). See also Section II(B) below.

§§35.1-35.251. But if the OHA hearing officer renders a decision with which DPW is dissatisfied, the Secretary of DPW has the right to unilaterally reverse that decision. Perhaps most importantly, Pennsylvania's administrative law precludes systemic challenges before OHA; a provider may only challenge the *application* of the methodology to that provider. *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 30 (3d Cir. 1989), *cert. denied*, ___ U.S. ___, 110 S. Ct. 3213 (1990), *cert. granted and aff'd on other grounds*, ___ U.S. ___, 111 S. Ct. 1138 (1991); *cf.* Pet. Br. at 22.

Practical experience with DPW's administrative adjudication also teaches that on the whole, the process is fraught with delay and difficulty – obstacles which could prove fatal to the hospital seeking relief in view of the economic “cross-fire” in which many hospitals are being “trapped.” *West Virginia University Hospitals, Inc. v. Casey*, *supra*, 885 F.2d at 14. A hospital, critically ill from Petitioners' toxic rate-making, could well expire on the OHA operating table in the hands of Petitioners' administrative officials.

Here, the “lop off” and fictitious “findings” and “assurances” infected the system itself, and would not have been subject to OHA review. Absent a federal court remedy, there existed no meaningful basis for the providers to have challenged the validity of the state's reimbursement methodology. Since system-wide deficiencies were at issue, and given the limitations imposed on the ability of Pennsylvania hospitals under the state's administrative procedures to challenge those deficiencies, this case presents atypical features making review of *Wilder* in this case inappropriate.

C. Petitioners Have Only To Fear Their Own Illegal Agency Action; They Can Hardly Be Heard to Complain That Suits By Providers Furnish A Basis To Reconsider *Wilder*.

While Petitioners wave the bloody shirt of a torrent of federal Medicaid litigation, they totally ignore the fact that this litigation resulted from a bald scheme by Petitioners to "lop off" roughly 14% from hospital reimbursement in direct contravention of Pennsylvania's self-prescribed (and binding) State Plan. Pet. App. 21a-22a. This illegality was compounded by provision of bogus "assurances" to HCFA respecting the reasonableness and adequacy of the rates which evolved from *sub silentio* changes to the approved State Plan methodology, and which, as both lower courts concluded, were not predicated on any analysis or studies of hospital costs or other considerations needed logically to support the "findings" explicitly required by federal statute and regulation. Given the extremity of the agency conduct which precipitated this case, Petitioners can hardly be heard either to complain about a torrent of Medicaid litigation or to argue that reconsideration of *Wilder* is here appropriate.

That the providers which were subjected to Petitioners' machinations should have sought relief in federal court is not surprising. As a matter of federal law, participating hospitals must treat the medically indigent; this requirement exposes them to ever-increasing economic distress as utilization rises, the cost of care increases and reimbursement rates decrease. Indeed, Petitioners *admitted* in the District Court that less than 20% of Pennsylvania's hospitals were being reimbursed for their reported costs as a result of DPW's *sub silentio* modification of the

rates prescribed under the State Plan. By this evasion of statutory funding responsibilities, Petitioners effectively sought to have the cost of medical care for the indigent subsidized by private hospital resources.⁷

States have little to fear if they avoid the temptation to evade compliance with statutory funding responsibilities and to deprive hospitals of their statutory rights. The fact is Petitioners disregarded their own State Plan, and gamed their reports to HCFA. Petitioners' suggestion that to shift reimbursement oversight from the federal bureaucracy to the federal courts "will have dramatic and potentially devastating repercussions upon the fiscal integrity of states which participate in the Medicaid Program" (Pet. Br. at 24) is truly a red herring. In fact, this lawsuit was about whether Petitioners would live up to the law, in particular the State Plan which Pennsylvania created and under which Pennsylvania was reimbursed by the federal government pursuant to a federal statute requiring Pennsylvania to observe the State Plan's terms. When Petitioners suggest that control over hospital costs is at issue, what Petitioners really are saying is that they should be left to their unfettered discretion to afford

⁷ It should also not be surprising that many hospitals, particularly urban hospitals treating heavy concentrations of the medically indigent, have been forced to seek bankruptcy protection or are teetering on the precipice of bankruptcy. See Resp. App. at 2a. This will inevitably and inexorably produce access crises, in contravention of the purpose of the Medicaid program. See 42 U.S.C. §1396a(a)(13); contrast Pet. Br. at 23 with Pet. App. at 89a. This problem is only exacerbated for the disproportionate share institutions whose concentration of medically indigent patients is recognized to make the cost of care even greater.

inadequate reimbursement as it suits Pennsylvania's budgetary goals. That Petitioners press so hard to deny a federal remedy speaks volumes about their true agenda – the opportunity to act with unfettered discretion and without effective and objective oversight.

The federal courts were properly held open to police Petitioners' abuse. In view of the agency conduct at issue, this case scarcely presents the occasion to consider otherwise.

II. PETITIONERS FAIL TO PRESENT A COMPELLING BASIS FOR REVIEW OF THE RULING ON THE DISPROPORTIONATE SHARE ADJUSTMENT

Petitioners also assert that this case presents important questions concerning the scope of the disproportionate share relief that federal courts may award against states under the auspices of the Boren Amendment. This is hardly the case. Rather, in an effort to underscore the alleged significance of the decision below, Petitioners have exaggerated the scope of the disproportionate share ruling. When that ruling is properly portrayed, it becomes clear that there exists no compelling basis to grant the writ.

A. The Decision That Petitioners Would Have This Court Review Is Not Of General Applicability But Is So Narrow As To Not Warrant Review.

In addition to invalidating Pennsylvania's base rates, the Courts below invalidated as inadequate the special

disproportionate share add-on payment (pursuant to 42 U.S.C. §1396r-4(c)) of 2.5% applied to co-respondent Temple.⁸ Petitioners seek to challenge the merits only of the latter ruling, a ruling which applies to but a narrow corner of the Medicaid legislation. Petitioners then erroneously suggest that the Court of Appeals dispositively construed the Medicaid statute as it relates to disproportionate share add-ons, and that the Petition squarely raises important questions pertaining to the scope of this statutory provision.

Federal law expressly prescribes which hospitals are, at a minimum, "deemed" qualified to receive Medicaid disproportionate share adjustments. 42 U.S.C. §1396r-4(b). As they existed at the time Pennsylvania established the disproportionate share formula at issue, the statute and regulations afforded states the alternative of either (1) adopting an add-on based on the formula prescribed by Congress for analogous adjustments under the Medicare program under 42 U.S.C. §1396r-4(c)(1), or (2) developing a suitable alternative add-on formula under 42 U.S.C. §1396r-4(c)(2).⁹

⁸ As relief, Pennsylvania was ordered prospectively to devise its own replacement plan for disproportionate share adjustments, based on proper findings and assurances and consistent with the Medicaid statute. Pennsylvania was ordered to pay an additional amount, in the interim, only as to Temple.

⁹ When Pennsylvania submitted its now invalidated and superseded adjustment formulas to HCFA, there existed only the two alternative approaches, now codified as 42 U.S.C. §1396r-4(c)(1) and (2). Congress added a separate formulation

(Continued on following page)

In striking Pennsylvania's 2.5% adjustment to Temple, the District Court grounded its decision on several bases. The Court partially rested its decision on the fact that the deviation between Pennsylvania's add-on percentage for Temple and that specifically authorized under the Medicare prong of §1396r-4(c)(1) was so great as to not even be in the same "ball park." The 2.5% adjustment, which was the maximum adjustment allowed by the state, was approximately *one-eighth* as much as the adjustment which would have been derived under the Medicare formulation.

The Court alternatively ruled, however, that the disproportionate share adjustment was invalid on grounds which did not turn on the meaning of the statute, invalidating Temple's 2.5% adjustment on the basis of gross procedural and other generic flaws infecting Pennsylvania's adoption of that adjustment. The District Court explained that the disproportionate share adjustment (like Pennsylvania's base rates) were adopted without any underlying findings or conclusions pertaining to its adequacy, and in contravention of the levels warranted under "defendants' own calculations." Pet. App. 79a, 80a. Rather, Pennsylvania had arbitrarily backed into

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under Section 4703(a) of the Omnibus Budget Reconciliation Act of 1990, P.L. No. 101-508, now codified as subsection 4(c)(3). Moreover, HCFA has recently proposed regulations to further modify the rules in this area. 56 Fed. Reg. 56132 (Oct. 31, 1991). The subsequent modification of the statute and HCFA's recent actions independently diminish any conceivable continuing significance of the decisions below.

adjustments ranging from 0.5% to 2.5% by “simply allocat[ing]” dollars to these adjustments based solely upon budgetary considerations having nothing to do with the actual added costs incurred by hospitals caring for a disproportionate share of low income patients. Pet. App. 80a-81a. These rulings clearly did not hinge on an interpretation of §1396r-4 at all.

Having so concluded, the District Court ordered Pennsylvania prospectively to devise and implement a proper disproportionate share adjustment as part of its revised state plan in compliance with §1396r-4 and, only on an interim basis, to pay Temple a 10% disproportionate share adjustment that was designed to prevent the hospital from suffering significant harm in its continuing treatment of a disproportionate share of indigent patients pending corrective action by DPW.¹⁰ In awarding Temple a 10% adjustment purely as a form of interim relief, the District Court reasoned that it was fair beyond doubt to peg the add-on reimbursement for Temple temporarily at a level less than half of the amount that would be concededly payable if Pennsylvania had elected to adopt the first and most clear-cut disproportionate share approach authorized by Congress, as provided for under §1396r-4(c)(1). In so ruling, the District Court stressed

¹⁰ The District Court effectively granted permanent declaratory and injunctive relief to the *Einstein* Respondents and other hospitals to the extent that it ordered Pennsylvania to revise its state plan on a prospective basis. The claims of the disproportionate share *Einstein* Respondents for interim relief as to disproportionate share adjustments were resolved by the settlement, discussed in Section II(B) below.

that "the statute does not mandate any particular level of payments," and generally recognized that it afforded states "a considerable amount of flexibility." Pet. App. 81a, 82a. The District Court thus sent Pennsylvania "back to the drawing board" in the face of its multi-flawed disproportionate share approach, but did not determine dispositively the minimum adjustment that might properly be adopted by a state if supported by appropriate reasoning, findings and conclusions.

For apparent reasons, the Court of Appeals did not directly address the scope of §1396r-4(c)(2). Rather, the Court of Appeals simply sustained the District Court's ruling that the disproportionate share add-on payment to Temple was unlawful, and then found that an interim remedy crafted by the District Court and gauged at less than 50% of an amount clearly authorized by statute was not an abuse of discretion.

There is no decision by any of the Circuits to date which analyzes §1396r-4(c)(1) or (2). In the absence of a conflict on this issue, the narrow question of the proper standards for formulating a small portion of the overall Medicaid payments, to a minority of participating hospitals, would not be worthy of plenary review by this Court. Given, however, that this issue was never even reached by the Court of Appeals, this case is *a fortiori* unworthy of certiorari.

B. The Case Has Been Settled, And Further Review Would Essentially Be An Academic Exercise.

A settlement agreement was entered into during the pendency of this appeal and approved by and entered into the record of the District Court. This settlement agreement embodied negotiated rates that have already been *included* in a new State Plan submitted by Pennsylvania to HCFA, and approved. The new State Plan supersedes totally the State Plan which the District Court invalidated. Under the new State Plan, Petitioners have agreed to pay a far *higher* disproportionate share adjustment to Temple and the other qualifying hospitals than DPW was required to pay under the interim relief order (as to Temple) or than it would have paid generally (to the other qualifying hospitals) by applying the same formula. The fact that the parties have arrived at a settlement which provides for on-going payment of higher disproportionate share adjustments than were ordered by the lower court – and which would continue to be paid under the terms of the settlement agreement even if this court were to grant review and reverse – renders academic Petitioners' request for review, and makes this case inappropriate for certiorari.

Moreover, the current State Plan includes a schedule of disproportionate share adjustments and a formula which produces add-ons that closely approximate those that would be paid under the Medicare program prong of §1395r-4(c)(1). In Temple's case, this adjustment is significantly *higher* than the interim rates the lower courts approved. Given the obligations already undertaken by Petitioners, Petitioners should not be heard to complain

as to the affirmance of the interim disproportionate share adjustments below.

C. Review Should Be Denied Since The Statutory Issue Was In Any Case Correctly Decided Below.

Although the issue need not even be considered by this Court because the disproportionate share adjustment issue was decided and affirmed on appeal on far narrower alternative grounds, Pennsylvania's 0.5% to 2.5% disproportionate share adjustment brackets did not satisfy the requirements of §1396r-4(c)(2), and the District Court's alternative conclusion that the adjustment paid to Temple was substantively inadequate was in any case correct.

Petitioners effectively contend that the states were given unfettered discretion by Congress under 42 U.S.C. §1396r-4(c)(2) to adopt any disproportionate share add-on formula which provides for any adjustment amounts, however minimal, provided that qualifying hospitals are paid adjustments which, in some rough fashion, increase based on the degree by which their Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate. Pet. Br. at 31. Petitioners assert that imposing any greater burden on them violates the rule of *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17 (1981). This argument is disingenuous.

Petitioners' argument requires reading subsection (c)(2) in complete isolation, and divorced from the context of the inter-related provisions of §1396r-4(c). It is well established, however, that:

A statute is passed as a whole . . . and is animated by one general purpose and intent. Consequently, each part or section should be construed in connection with every other part or section so as to produce a harmonious whole. Thus it is not proper to confine interpretation to the one section to be construed.

SANDS, 2A SUTHERLAND STATUTORY CONSTRUCTION §46.05 at 90 (4th ed. 1984) (footnotes omitted) and cases cited therein; see *United States v. Vogel Fertilizer Co.*, 455 U.S. 16, 24-26 (1982) (interpretation must have fidelity to overall statutory framework and legislative history); *National Muffler Dealers Ass'n, Inc. v. United States*, 440 U.S. 472, 477 (1979) (interpretation of subprovisions must be harmonized with statute's "origin and purpose").¹¹

In the present case, the more generally worded provisions of subsection (c)(2) are properly construed by harmonizing that section with subsection (c)(1). As HCFA

¹¹ In addition, where a general provision of a statute follows the enumeration of specific item, the general provision should be interpreted in a manner that is consistent with the provision more specifically enumerated. *Miami Heart Institute v. Sullivan*, 868 F.2d 410, 413 (11th Cir. 1989); see *Harrison v. PPG Industries, Inc.*, 446 U.S. 578 (1980). Petitioners' contention that the "alternative" approach authorized by subsection (c)(2) leaves the adjustment levels completely open to a state's discretion, and may be divorced from the Medicare formula touchstone referenced in subsection (c)(1), violates this principle as well.

has observed, under (c)(1), Congress specified not only that states might employ the federal Medicare percentage disproportionate share formula for reimbursing qualifying disproportionate share hospitals under Medicaid, but that when this election is made, that percentage figure must be multiplied by "[a]n amount *at least equal* to the . . . hospital's Medicaid operating costs." Emphasis added. See 55 Fed. Reg. 10078 (Mar. 19, 1990).¹² Thus, in authorizing states to use the Medicare formulation as one acceptable method for determining a Medicaid disproportionate share adjustment, Congress expressly created a floor, but did not erect a ceiling.

In light of established principles of statutory construction, Petitioner's construction of subsection (c)(2) makes little sense. Petitioners would attribute to Congress the intention of establishing alternative formulas, one of which contains a generous minimum payment standard but another of which, for no apparent reason, would authorize states to completely circumvent that standard. Such an approach would render the floor incorporated into subsection (c)(1) a logical nullity. The far

¹² Under §1396r-4(c)(1), states were given the option of applying the Medicare program disproportionate share percentage adjustment to the Medicaid "operating costs" otherwise being paid to participating hospitals that do not treat a disproportionate share of indigent patients (which "operating cost" payments might take a variety of forms, running the gamut from a fixed prospective payment rate to an actual cost-based reimbursement rate). If a state elects to use the Medicare percentage formula, it is not permitted under the statute to apply that formula to an amount which is *less* than the operating costs it reimburses participating hospitals generally under its Medicaid program.

more plausible interpretation is that Congress intended the alternative formula to produce an amount which is no less than the product of the Medicare disproportionate share adjustment and the state's standard operating costs.¹³

Given the palpable infirmities of Petitioners' position, the case was correctly decided below, and review is therefore inappropriate for this additional reason.

¹³ This interpretation is directly supported by the legislative history. Congress cited as its sole "example" of an add-on qualifying under the alternative formula of subsection (c)(2) the approach adopted by the State of Tennessee. In Tennessee, disproportionate share adjustments range from 6 to 34% above the base payment rates, and on the average produce rates 30% to 40% higher than those paid to non-disproportionate share facilities. *See* H.R. Rep. No. 100-391, 100th Cong., 1st Sess. at 526-527 (Oct. 26, 1987). These amounts range far above the maximum disproportionate share percentage amounts recognized by Medicare. Accordingly, as illuminated by this legislative history, Congress intended to use the Medicare formulation as a minimum amount, rather than to countenance a parsimonious alternative to the Medicare formula of the sort advocated by Petitioners.

CONCLUSION

For the reasons stated above, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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APPENDIX

1. All Respondents are corporations. Pursuant to Sup. Ct. R. 29.1, the following list identifies all parent companies and subsidiary companies, aside from wholly-owned subsidiaries, with which each Respondent is affiliated.

Albert Einstein Medical Center's parent company is Albert Einstein Healthcare Foundation.

Allegheny General Hospital's parent company is Allegheny Health Services, Inc.

Episcopal Hospital's non-wholly owned subsidiaries are VHA-East, Inc., Health Partners of Philadelphia, and Somerset Villas, Inc.

Germantown Hospital and Medical Center's parent company is the Germantown Medical Center Foundation. Germantown Hospital and Medical Center's non-wholly owned subsidiaries are GHC Services, Inc., and GHMC Management, Inc.

Magee Womens Hospital's parent company is Magee Womens Health Corporation.

Mercy Catholic Medical Center-Misericordia Division's parent company is Mercy Health Corporation.

Mercy Hospital of Pittsburgh's parent company is Pittsburgh Mercy Health Systems, Inc.

Montefiore Hospital's parent company is Presbyterian University Health Systems, Inc.

Presbyterian University Hospital's parent company is Presbyterian University Health Systems, Inc.

St. Christopher's Hospital for Children's parent company is Allegheny Health Services, Inc.

Western Pennsylvania Hospital's parent company is Western Pennsylvania Healthcare System, Inc. Western Pennsylvania Hospital's non-wholly owned subsidiaries are West Pennsylvania Foundation, West Pennsylvania Corporate Medical Services, and West Pennsylvania Care.

2. Children's Hospital of Pittsburgh has no parent or non-wholly owned subsidiary company.

3. Three hospitals designated by Petitioners as Respondents, Guiffre Medical Center, St. Joseph's Hospital and St. Mary Hospital, are no longer participants in the group of hospitals represented herein. St. Mary Hospital declared bankruptcy, obtained separate representation, and settled its claims against Petitioners. Guiffre Medical Center became Girard Medical Center, subsequently declared bankruptcy, has been reorganized as North Philadelphia Health Systems, and has settled its claims against Petitioners. St. Joseph's Hospital declared bankruptcy and has been represented separately in the proceedings below.
